MOVING BEYOND CHARITY CARE

to Upstream Community Benefit

Adventist Health

Executive Summary

Nonprofit hospitals and community benefit have a history that goes back over 50 years. Today, many nonprofit hospitals in the United States use community benefit requirements to bring what some might consider traditional healthcare services to a community setting: population health outreach, community relations partnerships, health education activities, and charity care. Community benefit reporting, as it stands, is used as an accountability mechanism for justifying nonprofit hospitals' tax-exempt status. In 2017, nonprofit hospitals provided $100 billion in community benefits, but did this investment improve the health status of the communities?

For the past decade, hospitals have been under scrutiny for their level of community benefit spending, specifically their charity care (care provided for free or at reduced prices to low-income patients), relative to their tax exemption. Focusing on a hospital's numerical benefit to the community is shortsighted and does not take into consideration measurable outcomes of the community benefit spending.

However, there is opportunity for the community benefit story to move beyond state and federal mandates, beyond traditional healthcare services, and beyond the numerical measure of services to improving the health of our communities.

Every hospital has its own philosophy and approach to community benefit, and the Affordable Care Act in 2010 ushered in updated reporting requirements with the goal that hospitals would try to better understand the health and social needs of their service areas and respond with actionable health programming and investment. Without explicit rules guiding hospitals' interventions or setting a baseline level for funding, priority areas or outcomes, community benefit programs and their spending vary greatly. Essentially, community benefit means different things to different hospitals, and measuring what counts as a successful community benefit investment still challenges hospitals across the nation.

The challenges created by a lack of standardized regulations or baseline have been further exacerbated by the COVID-19 pandemic. The future state of community benefit must consider the amplifying effect of COVID-19 on existing health disparities and the need for greater investment in a new era of health equity.

Considering the public health and healthcare impact that COVID-19 has brought to bear on hospitals and individuals, addressing health disparities becomes even more critical as we look to pandemic recovery and healthcare's future state.

Adventist Health's unique mission of "living God's love by inspiring health, wholeness and

hope" has always maintained a lens of equity. Adventist Health knows that to continue existing models of healthcare is to ignore shortcomings that have led to a steady increase in chronic disease, along with the cost of treatment. It's time not just for a fresh approach, but a revolutionary one. That's why Adventist Health is reshaping the role of healthcare through the creation of its Well-Being Division. We have restructured our entire organization to enable an intentional, focused investment into improving the well-being of individuals, organizations and communities. To achieve an aggregate improvement in well-being, Adventist Health has created a scalable, sustainable model for community benefit using a framework revolving around people, places and equity, modeled after the Well-Being In the Nation (WIN) index.[i]

This white paper reflects on the history of community benefit, the way we currently measure and count community benefit investment, and what policymakers can focus on when it comes to community benefit policy.

Background and History

57% of the hospitals in the United States are non-profit.[i]

In 2016, the latest year for which data is available, hospitals spent $95 billion on community benefits.[i]

Throughout the five-decade history of community benefit, the primary focus in the policy arena has been on the volume of hospital expenditures, and there has been ongoing debate about how much is enough and what kinds of expenditures are most appropriate.

Community benefit, a requirement of non-profit hospitals, was established in 1969 by the Internal Revenue Service (IRS) for hospitals to justify their tax-exempt status. Community benefit for hospitals was later overhauled and aligned in 2010 with the passage of the Affordable Care Act (ACA) [ii], which required hospitals to research the needs of their community through a community health needs assessment (CHNA). The aim of the CHNA process is for hospitals to collect both qualitative and quantitative data from their community every three years to better understand the health and social needs of where patients work, live, learn, pray, and play. CHNAs can be a simple checked box or a collaborative process to leverage resources and improve health through intentional strategies. Complying with only the minimal requirements is a lost opportunity, but a more granular deep dive can pinpoint care gaps worth prioritizing.

Many hospitals today rely on charity care and uncompensated care to make up the majority of community benefit investment, under the practical reality that there will always be uninsured and underinsured. Hospitals in low-income areas must spend more on free and subsidized care, which can mean they spend less on preventive community programs. Conversely, hospitals in affluent areas have the flexibility to spend more on community programs, arguably where the money is needed less. This dynamic perpetuates the status quo.[iii]

Public Health Partners

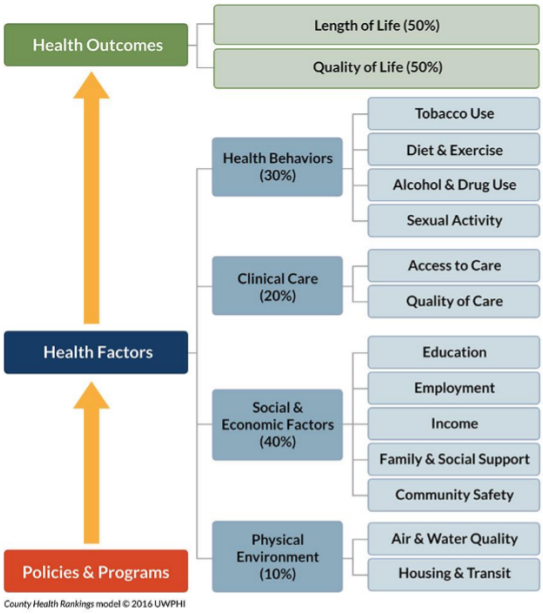
A shift toward measurable community health improvement requires hospitals to view themselves as part of the larger community health ecosystem. The CHNA gives hospitals an opportunity to look outside their walls and engage new partners to consider the breadth of community health needs and properly prioritize those needs.

County health departments must also conduct a community health assessment and develop a regional health improvement plan to retain their accreditation. COVID-19 has shown us that health systems and public health departments overlap. Collaboration between these two natural partners is essential. Collaborative and collective processes can help maximize

programming specific to each partner's area of proficiency and minimize service duplication. Relatively simple policy changes could foster even greater collaboration with key community partners and move the policy discussion from the numerical tally of community benefit reporting to measurable outcomes.

Measurable Investment

Policymakers, regulators, and advocates have limited their focus to the numerical tally of charity care and community benefit services provided by hospitals, without consideration of measurable outcomes that are produced. An emphasis on charity reflects attention on fixing short-term needs rather than addressing systemic inequities that create an environment in which charity is necessary.



Eighty percent of a person's health is defined by social and economic factors, while just 20 percent of health status is shaped by medical care[iv]. Emerging community benefit strategies today have pivoted to addressing the social determinants of health and uplifting health equity. The social determinants of health are community-wide conditions shaped by broader economic, social, and political forces that impact health[v]. Examples of the social determinants include: education, access to quality healthcare, a safe living environment, clean air, and nutritious food options. Many of these conditions are known as "places," and research in the last few years has studied the relationship between zip codes where people live and their life expectancy. Since then, the expression: "Where you live defines how long you live," has been expertly referenced around the nation in public health demonstration projects.

When we think of our zip code defining how long we will live, we can immediately see why investing in the social determinants of health is critical. Community benefit and its direct relation to health equity helps ensure that everyone has the opportunity to attain their full health potential. Moreover, a growing body of research highlights the importance of upstream factors that influence health and the need for policy interventions to address those factors—in addition to clinical approaches and interventions aimed at modifying behavior.[vi]

In recent years, hospitals have done well to create new programs and partnerships in many social determinants of health domains. Hospitals have started to embrace the philosophy and

recognition that without addressing the root cause of underprivileged patients' poor health status and outcomes, the quality medical care hospitals provide will never truly have an impact.

Future of Community Benefit: Policy Recommendations

Without additional or revised guidance from federal regulatory agencies, nonprofit hospitals must continue to submit Form 990 Schedule H and surmise sufficient commitment to avoid any penalties that might be forthcoming. Meanwhile, millions of dollars have been, and are being, spent in hopes of improving the health status of communities. Each hospital has an opportunity to direct its activities in ways that are consistent with its mission and that make a documentable difference. Activities conducted under the auspice of community benefit, or with funds allocated to community benefit, should be selected from evidence-informed programs and evaluated with specific measures.

To promote collaboration and meaningful investment in improving communities' health status, we encourage policymakers to:

- Incentivize health systems to incorporate findings and priorities from their community health needs assessments (CHNA) into hospital strategy, as well as align the community health process outcomes to outcome measures.
- Change frequency of the CHNA from three years to five years to align with county health departments and to give more time to see the change created by interventions.
- Revise Schedule H of the 990 to relate activities directly to measures of benefit to the community, including measures of health status, and to recognize the respective allocation of funds to allowable categories other than charity care and uncompensated care.

---

[i] Well-being in the Nation Measures | LiveStories (winmeasures.org)

[ii] IRS. (2020, September). Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r). Retrieved from: https://www.irs.gov/charities-nonprofits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[iii] Sanborn, B. (2019, August 16). IRS revokes tax-exempt status for county-run hospital, raising specter of more actions against nonprofits. Healthcare Finance. Retrieved from: https://www.healthcarefinancenews.com/news/irs-revokes-tax-exempt-status-county-run-hospital-raising-specter-more-actions-against

[iv] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024

[v] Sg2, (2020). Social Determinants of Health: Stitching Together Solutions. PUB-0420-024-SDH

[vi] Castrucci, B., & Auerbach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. Health Affairs Blog, 10.